

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/11/2011	
NAME OF PROVIDER OR SUPPLIER HILLCREST CENTRE FOR HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVENUE JEFFERSONVILLE, IN47130			
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F0000	<p>This visit was for the investigation of Complaint #00088481.</p> <p>Complaint #00088481 - Substantiated Federal/state deficiencies related to the allegations are cited at 425.</p> <p>Unrelated deficiencies cited</p> <p>Survey dates 4/11/11</p> <p>Facility number 000110</p> <p>Provider number: 155203</p> <p>AIM number: 100271120</p> <p>Survey team Jennie Bartlett RN</p> <p>Census bed type: SNF: 0 SNF/NF: 87 Total 87</p> <p>Census payor type Medicare: 15 Medicaid: 70</p>			F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of correction for the survey ending April 11, 2011. Due to the low scope and severity of the survey findings, please also find enclosed sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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F0164 SS=D	<p>Other: 2 Total 87</p> <p>Sample: 9</p> <p>These deficiencies reflect the findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/13/11 by Suzanne Williams, RN The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>						

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	<p>Based on observatton, intterview and record review, tthe ffacilityty ffailed tto ensure care was provided privattely ffidr offi 3esidentts observed during care in a sample offi 9 residentts (Residentt Q Failure tto provide privacy also affectedt Residentt H who was Residentt Cs roommatte</p> <p>Findings include:</p> <p>On 4/11/11 att5:45 a.m., tthe door tto Residentt G room was closed. Upon knocking on tthe door,a voice inside tthe room was heard butt tthe words were nott understtandable The door was cracked open, and tthe voice inside tthe room indicatedd itt was okay tto entterResidentt H was lying in tthe bed by tthe door witht eyes open Residentt Cs emptyy bed was nextt tto tthe windowThe curtain was nott pulled between tthe ttwo beds The door tto tthe residentt's resttroom was open and sttanding between tthe room door and tthe resttroom door was CN#6,</p>			F0164	<p>F164 Requires that the resident has the right to personal privacy and confidentiality of his or her personal and clinical records. The facility will ensure this requirement is met through the following:1. Resident C and H were not harmed. Resident C and H privacy curtains are pulled with care. All residents privacy curtains will be pulled when care is provided to ensure privacy and dignity.2. All residents have the potential to be affected. See below for corrective measures. 3. Dignity and Privacy procedure were reviewed with no changes made. (see attachment A) Nursing staff was in-serviced on the above procedure.4. The DON or designee will utilize the Nursing monitoring tool (see attachment B) to ensure resident' s privacy is being maintained during care by doing rounds twice daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly.5. The above corrective measures will be completed on or before April 15, 2011.</p>		04/15/2011

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	<p>who had responded to the knock on the door. CNA #6 entered the restroom where Resident C was seated on the toilet but did not shut the door. CNA #6 completed care in the restroom, assisted the resident into her wheelchair and pushed the wheel chair out of the restroom into the room. The hem off the resident's gown was near the top of the legs with the legs and part of the briefs exposed in full view of Resident H.</p> <p>CNA #6 transferred Resident C from wheelchair to bed with the curtains between the beds of Residents H and C completely open. Resident H's eyes were open. Resident C was in bed in full view of Resident H, with her gown to the waist with briefs and legs exposed. During interview at this time, CNA #6 indicated she would get the nurse to assist her to position Resident C in bed and walked toward the door. CNA #6 was asked if Resident C would like</p>						

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F0241 SS=D	<p>tto be covered beffiore CNA#6 leffi tthe room and CNA #6 indicatted she was coming rightt back and Residentt C remained in bed witht brieffi and legs exposed The bed curtains between tthe ttwo residentt's beds remained open.</p> <p>The ffiacility policy, "Your Rightts as a Nursing Home Residentt" was provided by tthe Unitt Manager on 4/11/11 att2:35 p.m. Review offi tthe policy indicatted "...You have tthe rightt ttto..Privacy in your room and during batthing medical ttreatmentt and personal care...."</p> <p>3.1-3(p)(4)</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observatton and record review, tthe ffiacilityt ffiailed ttto ensure residentt dignitty was mainttained by screening residentt's who were parttally uncovered, ffirom view during sleep, ffiob offi 4residentts</p>			F0241	<p>F241 Requires the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility will ensure this requirement is met through the following:1. Resident</p>		04/15/2011

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	<p>visible ffrom outside in a sample offi 9. (Residentts E, F, and G)</p> <p>Findings include:</p> <p>Upon arrival att tthe ffiacilityt ffrontt parking lott on 4/11/11att4:15 a.m., when itt was dark, CNA #10 was visible sttanding in tthe room offi a residentt seattted in his wheel chair A lightt and tthe ttelevision in tthe room were on. CNA #10 was observed tto be wearing a black ttshirtt wittth yellow writtng</p> <p>1. During Inittal Tour offi tthe ffiacilityt immediattely affier arrival on 4/11/11 att4:15 a.m., Residentt E was observed in bed wittth eyes closed. Residentt E's room was ttwo doors away ffrim tthe resideht room observed upon arrival att tthe ffiacilityt Lighttng in tthe room was on low, and tthe residentt's window shades were open tto tthe parking lott immediattely outtside tthe residentt's room. The residentt's upper body was covered wittth a</p>				<p>E, F, and G were not harmed. All residents were interviewed for preferences including E, F, and G to ensure they wanted their curtains pulled at night. All residents preferences were careplanned and followed accordingly. During care, curtains will be pulled. 2. All resident's have the potential to be affected. See below for corrective measures. 3. Dignity and Privacy procedure were reviewed with no changes made. (See attachment A) Nursing staff was in-serviced on the above procedure. 4. The DON or designee will utilize the Nursing monitoring tool (See attachment B) to ensure resident's privacy is being maintained during care by doing rounds twice daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter. The DON or her designee will monitor by doing rounds at night to ensure that curtains are pulled according to the residents preference to maintain privacy and dignity. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action will be adjusted accordingly.5. The above corrective measures will be completed on or before April 15, 2011.</p>		

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	<p>white blanket but her bare elevated legs were fully exposed</p> <p>2. During Initial Tour at 4:50 a.m. on the 2nd East Hall Residents F and G were observed in bed. Lighting in the room was on low. Resident G was in the bed closest to the window. Her eyes were closed and respirations were even. The resident's gown was to the waist and her briefs and bare legs were exposed. Resident F was lying on the left side covered with a sheet. The window shades were fully open onto a floor level grassy small hill leading to a parking lot with cars parked. The residents would be visible to passersby who walked up the hill from the parking lot.</p> <p>The facility policy, "Your Rights as a Nursing Home Resident" was provided by the Unit Manager on 4/11/11 at 2:35 p.m. Review of the policy indicated "Basic Rights You have the right to be treated with respect and dignity in recognition</p>						

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F0282 SS=D	<p>offi your individualitty and prefferences.."</p> <p>3.1-3(tt)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and intterview tthe ffiacilityt ffiailed tto ensure tthe physicia's orders ffiior as needed medicatton were ffiollowed ffioff 3esidentts reviewed relatted tto physicia's orders ffiior medicattons in a sample off9. (Residentt B)</p> <p>Findings include:</p> <p>The clinical record ffiior Residentt B was reviewed on 4/11/11 att7:00 a.m.</p> <p>Physician's orders ffiior March2011 included an order originally received on 6/4/09, ffiior "Hydrocodone-APAP 10/500 [narcottc pain medicatton], ttake1</p>			F0282	<p>F282 Services provided by Qualified PersonsThe facility will ensure this requirement is met through the following:1. Resident B was not harmed. An order for routine pain medication was obtained and is being administered as ordered. The facility did an audit of all physician's orders to ensure medications were available to be given according to the physician's order.2. All residents have the potential to be affected. All physician's orders were reviewed to ensure they were followed accordingly. 3. The policy and procedure for physician's orders was reviewed and no changes made. (See attachment C) Nursing staff were in-serviced on the above procedure.4. All new physician's orders will be reviewed daily to ensure they are being carried out according to the order. The DON or her designee reviews all the new physician orders that are obtained that day and contact the pharmacy to</p>		04/15/2011

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	<p>tablet by mouth every 6 hours routine for pain. The orders also included, but were not limited to an order originally received 11/12/10 for "Naproxen [antiinflammatory medication] 375 mg tablet take one tablet by mouth 2 times a day as needed."</p> <p>The Care Plan Worksheet with date of 8/10/10 and updated most recently on 2/8/11 indicated "Problem: The resident has the potential for pain in the following areas: joint pain hx[history] of osteomyelitis." Interventions included, but were not limited to "Lortab 10/500 i [symbol for 1] po [by mouth] q [every] 6 hr [hours]," and, "11/12/10 Naprosyn 375 mg i po bid [two times daily] prn [as needed]."</p> <p>Nurses' Progress Notes for 3/5 through 3/7/11 indicated the resident's Hydrocodone 10/500 was not available from the pharmacy.</p>				<p>ensure they will be delivered. If the medications are not available, the DON will contact pharmacy and the pharmacy will contact the back-up pharmacy located in Jeffersonville to have the medications assessable for delivery. The nurses are aware that if a medication is not available, they are to contact the DON and she will have the pharmacy call the medication into the back-up pharmacy so it can be given per the physician's order. The DON or her designee will utilize the Nursing monitoring tool (See attachment B) daily times four weeks, then weekly thereafter. The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before April 15, 2011.</p>		

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	<p>The March 2011 Medication Administration Record indicated a handwritten notation off See prn flow sheet in the entry next to the Naproxen [antoinflammatory medication] 375 mg tablet take one tablet by mouth 2 times a day as needed."</p> <p>The PRN Medication Flow Sheet for March 2011 indicated Naproxen was administered to Resident B on 3/6/11 at 00:00 midnight, 6:00 a.m., 12:00 noon, and 6:00 p.m. On 3/5/11 at 6:00 p.m., the "Reason" for the medication indicated "Hydro not here NP [nurse practitioner] here Give prn titration [symbol for narcotic/o pain." "Reason" for the administration on each administration on 3/6/11 indicated "Out of routine Documented failed to indicate an order was received to administer the Naproxen four times daily as needed instead of two times daily</p>						

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F0323 SS=D	<p>as needed.</p> <p>During interview related to the lack of Hydrocodone on 4/11/11 at 2:40 p.m., the facility Nurse Consultant nodded when the use of the Naproxen instead of Hydrocodone was discussed.</p> <p>3.1-35(g)(2)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident at risk for falls was transferred with supervision off two and using safety braking devices off of 3 residents observed during transfer in a sample of 9. Resident Q</p> <p>Findings include:</p>			F0323	<p>F323 Free of Accidents/Hazards The facility will ensure this requirement is met through the following: 1. Resident C was not harmed. Staff was trained on the transfer policy and how to properly transfer resident C. 2. All residents have the potential to be affected. See below for corrective measures. 3. The transfer policy and procedure was reviewed with no changes made (See attachment D). Nursing staff were in-serviced on the above procedure. 4. The DON</p>		04/15/2011

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	<p>During observatton offi care on 4/11/11 att5:45 a.m., Residentt C was seattted on tthe ttoilett with CNA #6 assisttng her. CNA # 6 instttuctted tthe residentt tto hold tto tthe wall grab bar nextt tto tthe ttoilet, and using a gaitt belt, tthe CNA assisted tthe residentt tto sttand while she cleaned urine ffirom tthe resideht skin. The residentts buttocks sagged ttoward tthe ffiopand she appeared tto be hanging ffirom tthe grab bar, bearing some weightt on tthe ffiieett. Using tthe gaitt belt, CNA #6 assisted tthe residentt tto ttransffier tto tthe wheel chair. The residentts wheel chair was rolled tto her bedside, and CNA #6 used tthe gaitt belt tto assistt Residentt C tto ttransffier tto tthe bed. As tthe residentt was ttransffierred onto tthe bed, the residentt appeared tto bear minimal weightt, and tthe bed was observed tto move as tthe residentt was seattted onto tthe edge offi tthe bed, leaning back. During intterview att tthis ttme CNA #6 indicattted some offi tthe</p>				<p>or her designee will conduct observations on staff transferring residents to ensure that the staff is transferring residents appropriately. The DON or her designee will supervise three transfers daily times four weeks, then weekly times four weeks, then monthly times two months, then quarterly thereafter (See attachment D). The audits will be reviewed in the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before April 15, 2011.</p>		

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	<p>resident's beds roll, and on some, the brakes do not work. At this time CNA #3 entered Resident's room to assist. During interview at this time about bed brakes, CNA #3 stepped on the brake to the bed wheel off Resident's bed, and the bed no longer moved when pushed against CNAs #3 and #6 positioned the resident and completed care.</p> <p>The clinical record for Resident C was reviewed on 4/11/11 at 6:05 a.m.</p> <p>Nursing Progress Notes for 3/21/11 at 6:40 p.m., indicated Resident C was "...laying [sic] in floor in front of w/c [wheel chair]...." Nursing Progress Notes for 3/21/11 through 4/1/11 indicated that x-rays did not show fracture and the resident complained of pain to the knees.</p> <p>A Physician's Order and Progress Record from a medical</p>						

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	<p>appointment dated 3/29/11, indicated "Patient [symbol for with] end stage OA [osteoarthritis] + [arrow pointing down] ambulation in both knees..." The progress note indicated the resident received injections of the anti-inflammatory medication Cortisone, to both knees</p> <p>A physician's order, dated 4/1/11, indicated "PT [physical therapy] to eval [evaluate] and tx [treat] as indicated due to decline in ambulation."</p> <p>The Physical Therapy Evaluation, dated 4/4/11, indicated "Circumstances leading to referral of 3/21/2011, XR [x-ray] came back (-) [negative] of fracture. Resident does [complaints of] knee pain. Cortisone shot [illegible word] but still doesn't [weight] bear on RLE [right lower extremity]... Assist... Mod Max [moderate to maximum] A X 2 [assist off to] R knee</p>						

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	<p>buckling...."</p> <p>The Quarterly/Significant Change Pain Assessment dated 4/5/11, indicated "...If having pain or receiving pain medications, describe how pain affects the following areas...Activities of Daily Living: makes more difficult for transfers."</p> <p>The residents care plan, dated 4/4/11, indicated "Problem: gait difficulty" with the goals including "Transfer (symbol for with) min mod [minimum to moderate] A X 2" with interventions toward the goal to be provided by physical therapist</p> <p>The CNA Assignment Sheet was provided by LPN #8, Resident C's nurse, on 4/11/11 at 6:15 a.m. The assignment indicated Resident C required the assistance of one person for transfers</p> <p>A second CNA Assignment Sheet for</p>						

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F0425 SS=D	<p>Residentt C was provided by tthe Directtor off Nursing(DON) on 4/11/11 att3:45 p.m. During intterview att tthis ttttthe DON indicatted tthe assignmentt had been updatedt"lastt week' tto indicatte Residentt C should be assisted by ttwo ffor ttransffiers and thatt tthe ffirstt assignmentt sheett provided was nott tthe correctt one</p> <p>3.1-45(a)(2)</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and</p>			F0425	F425 Pharmacy Services- Routine Drugs and Biologicals1.		04/15/2011

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	<p>interview tthe ffacillitty ffailed tto ensure tthe residents routtne pain medicattons were available ffor administtratton The defficientt practtce affiectted offi 3esidentts reviewed relatted tto availabilitty offi medicattons in a sample offi residents (Residentt B)</p> <p>Findings include:</p> <p>The clinical record ffor Residentt B was reviewed on 4/11/11 att7:00 a.m.</p> <p>Physician's orders ffor March2011 included an order originally received on 6/4/09, ffor "Hydrocodone-APAP 10/500 [narcottc pain medicatton], ttake1 tablett by moutht every hours routtne ffor pain'</p> <p>The Care Plan Worksheett with datte offi 8/10/10 and updatted mostt recently on2/8/11 indicatted "Problem: The residentt has tthe pottenttal ffor pain in tthe ffiollowing</p>				<p>Resident B was not harmed. An order for routine pain medication was obtained and is being administered as ordered. All resident's physician orders, including resident B, were reviewed to ensure that all medications were in the facility and available to be given. 2. All residents have the potential to be affected. All physician's orders were reviewed to ensure medications were available to be given per physician's orders. 3. The policy and procedure related to emergency pharmacy services and refilling of prescriptions were reviewed with no changes (See attachment E). Nursing staff were in-serviced on the above procedures.4. The DON or her designee reviews all physician orders to ensure that the medications are available to be given per order. If the medication is not in the facility and is due then the DON will call the pharmacy and they will call their back-up pharmacy in Jeffersonville regarding the medication and the medication will be delivered and given per order. The DON or her designee will utilize the Nursing monitoring tool (See attachment B) to ensure resident's medications are available to be given to the resident as ordered daily times four weeks, then weekly times four weeks, then every two weeks times two months, then monthly thereafter. The audits will be</p>		

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	<p>areas: jointt pain hx[histor] offi osteomyelitts" Interventtons included, butt were nott limitedt to "Lorttab10/500 i [symbol ffio] po [by moutt] q [every] 6 hr [hours]."</p> <p>Nurses' Progress Nottes ffio3/5/11 att6:30 p.m. tthrough 3/7/11 att 4:00 a.m., indicattt the ffollowing 3/5/11 att6:30 p.m., "Rd [residentts] 1800 [6:00 p.m.] Lorttab 10/500 mg nott avail[available]. On call paged ffior orders Awaitng rttn [rettur] call. Rd. denies currentt discomffio:tt 3/6/11 att5:30 p.m., "[Symbol ffior nN.O. [new orders] concerning Lorttab Rd. denies discomffio:tt[Arrow pointng up] amb [ambulattng] [symbol ffior wit]h walker, outt to smoke@ breaks." 3/7/11 att3:00 a.m., "Res. [resident] has been c/o [complaining off]knee pain - is outt offi pain med nott ffound in EDK [emergency drug kit] - have called Nurse Practt[practttone] several X's [ttmes] - no one has called me back - call on call Dr. [docto] waitng ffior retturn call</p>				<p>reviewed in the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly.5. The above corrective measures will be completed on or before April 15, 2011.</p>		

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	<p>3/7/11 att3:30 a.m., "Called on call Dr. again." 3/7/11 att4:00 a.m., "On-call Dr. called back - N.O. give Lorttab5/500 ii [symbol ffior ttw]o now & ii q 6 hr [every six hours] routtne ttll Lorttab10/500 comes in. Res. notttffied -will give ii now."</p> <p>The Medicatton Administtrattton Record indicattted nine doses offi tthe Hydrocodone-APAP 10/500 were missed ffiron3/5/11 tthrough3/7/11 due tto unavailabilitty</p> <p>During intterview on4/11/11 att 2:15 p.m., RN #7 indicattted routtne medicatttons are ordered when tthe supply is running low by ffiixing a refill label tto tthe pharmacyShe also indicattted a local retttil pharmacy was used as a back-up pharmacy tto ffill orders iffi necessary She indicattted ffiacilitty sttaffi would pick up tthe medicatton att tthe local pharmacy.</p> <p>During intterview on4/11/11 att 3:30 p.m., tthe Assistantt Director offi</p>						

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	<p>Nursing indicated ffrom pharmacy order fforms provided tthat the Hydrocodone 10/500 was ordered by ffix ffrom the pharmacy on 2/25/11, sentt ffrom the pharmacy on 3/7/11, and received by the ffiacility on 3/8/11 att 12:30 a.m.</p> <p>During intterview on 4/11/11 att 2:45 p.m., tthe Directtor off Nursing and Nurse Consulttantt indicatted Residentt Bs Hydrocodone was ordered ffrom the pharmacy on 2/25/11, butt apparently the prescriptton could nott be ffilled att tthat tmesince the medicatton is a narcottc. The DON indicatted the ffiacility pharmacy does nott make deliveries on Sundays, so no delivery was received on 3/6/11. The DON indicatted since the medicatton was a narcottc, the ffiacility would have needed tto obtain a hard copy off the prescriptton ffrom the physician ffior the alternatte local pharmaçyn order tto obtain the medicatton there and tthat had nott been done</p>						

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	This federal tag relates to Complaint IN00088481. 3.1-25(a)						